ANNUAL NONPROFIT HOSPITAL
COMMUNITY BENEFIT STATEMENT
State Form 50654 (10-01)
Indiana State Department of Health
Indiana Code 16-21-9

I. Identification of Nonprofit Hospital

Name Of Hospital	
City Of Hospital	
Name Of Charity Benefit Representative	
Telephone Number	
Year Of Statement	

Eligibility Statement	Has the CEO identified your hospital as a "Nonprofit Hospital"?	Yes: _____ No: _____

II. Documentation of Previously Filed Information

NAME OF DOCUMENT	DATE FILED WITH ISDH	ANY CHANGES (yes/no)
Community Benefit Plan		
Original Long-Range Hospital Objectives for charity care		
Hospital Mission Statement		
List of Communities Served		
Needs Assessment		
Copy of Charity Care Policy		
Statement of Public Notice		

III. Identification of New Objectives (Optional)

ISDH	ANNUAL NONPROFIT HOSPITAL COMMUNITY BENEFIT STATEMENT

IV. Allocation of Dollars and Persons Served Under Adopted Charity Policy

List Last Three Years			
Persons Served in twelve-month period			
Charity Care Allocation	($)	($)	($)

V. Annual Community Benefit Programs and Net Cost of Operation

NAME OF PROGRAM	NET COSTS OF PROGRAM
1.	($)
2.	($)
3.	($)
4.	($)
5.	($)

Will hospital file additional paper document to provide more details or descriptions of Projects that were funded to support community services? ___Yes ____ No

If applicable, name of hospital web site that contains information on community benefits

www: _____

VI. Identification of Additional Non-Hospital Charity Costs.

ORGANIZATION PROVIDING CHARITY CARE	STREET ADDRESS	NET COSTS OF CHARITY CARE
		($)
		($)

Comments
